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The Honourable MaryAnn Mihychuk

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● (1535)

[*English*]

The Chair (Hon. MaryAnn Mihychuk (Kildonan—St. Paul, Lib.)): Welcome, everybody. We're here at the Standing Committee on Indigenous and Northern Affairs. We're talking about long-term care.

Welcome to our guests on the the video conference. Be sure when we get to questions that we're aware of whether we're addressing our guests here in Ottawa or on the video conference.

Before we get started, Canada is on a journey of reconciliation and the first part of it is truth. We always recognize the fact that we're on the unceded territory of the Algonquin people here in Ottawa. As a settler from the Prairies, I feel it's important for us to always recognize our history.

Going from there, I would try to read this but it would be a horrible insult. I understand it's the Mohawk word for "our home", which is very nice, and it's a long-term care facility. Then we have the UW-Schlegel Research Institute for Aging; and Bonita Beatty, a professor from U of S in Saskatchewan.

We're going to start with Tammy. All right. You have up to 10 minutes, and I'll try to give you a signal when we're getting close to the time, if you need it. We'll hear from all the presenters and then we'll go to rounds of questions.

Welcome to our committee.

Tammy, you can start off.

Ms. Tammy Cumming (UW-Schlegel Research Institute for Aging): Thank you.

I'm Tammy Cumming from the UW-Schlegel Research Institute for Aging in Waterloo, Ontario. I'm here to talk a little bit about a program that I'm responsible for there. It's a Ministry of Health and Long-Term Care-funded program called the Ontario Centres for Learning, Research, and Innovation in Long-term Care. This program is co-run by three organizations: the UW-Schlegel Research Institute for Aging in Waterloo, Baycrest Health Sciences in Toronto, and the Bruyère Research Institute in Ottawa.

We've been leading this program for a number of years and we just received renewed funding in the summer of 2017. The program's goal is essentially to support long-term care homes in building capacity by identifying and developing various resources to improve the quality of care and the quality of living for residents in long-term care.

The scope can be pretty broad. Today, I'm just going to talk a little about some of the work we are starting to kick off around supporting indigenous residents in long-term care.

In 2016, there were some identified gaps in some of the work we were doing in terms of addressing indigenous people's needs in long-term care. Stakeholder feedback in long-term care was giving us this information, and then the Ministry of Health and Long-Term Care was also identifying a need for us to address it. Therefore, we conducted a needs assessment, and we finished it in 2017. The needs assessment was basically trying to identify some gaps, and if there was anything that the program could do within its mandate to address those gaps.

The needs assessment involved interviews and meetings with some stakeholders in long-term care, and we had an advisory committee of people who were familiar with indigenous culture and long-term care supporting it as well.

There were a number of key findings and there's a full report about it. Some of the key findings I wanted to bring up today were that indigenous people have unique cultural needs that we need to be addressing and valuing when we're caring for them in long-term care. There's a growing body of evidence that suggests that when we're restoring culture and we're embracing culture, it can contribute to healing, and it may even have a protective factor for worsening health when in long-term care.

The other finding was that there's a lot of history in this country's legacy of colonization, historical trauma, racism, distrust in western medicine, and those are very unique considerations that we need to take into account when we're trying to address indigenous residents in long-term care, as well.

There's a real need to develop and identify resources that are already out there, and spread them across all long-term care homes, not just the long-term care homes that have the bulk of the indigenous residents but all the long-term care homes. This was one thing we heard from some of the stakeholders, the long-term care homes, that they have an indigenous resident moving into their home and they don't know how to ensure that they're supported culturally.

Of course, as always, it's really important for us to be partnering with indigenous people and organizations when we're doing any work.

Following the needs assessment, it was very evident that there was a role for the program in addressing and doing some of this work, but we weren't experts in indigenous culture, so, of course, we needed to identify partners and decided we wanted to form an advisory circle. That's primarily what I am going to talk about for the last few minutes here.

We spent some time thinking about the advisory circle, and we wanted members on the advisory circle to be experienced in long-term care and indigenous culture, but also to be representative of the northern and southern regions of Ontario as well. We began a bunch of phone calls and interviews to identify members for this circle. Without having an advisory circle to guide our work, we decided we'd better have some indigenous people on our team to help us with this recruitment work, so we hired an indigenous project assistant, and we had an indigenous facilitator guiding the process of recruitment. That was really important.

Once we finally identified the 11 members, we formally sent them a letter of invitation and included tobacco ties as a gift to show that we were wanting to incorporate their culture into the work we're doing.

We are happy to say six weeks ago to the day today we had our inaugural meeting. It was really very important for us to have an in-person meeting with the committee members. Nine of the 11 members were able to show up in person. We spent the entire meeting focused on building relationships and defining the way we were going to be working, so essentially an entire meeting about building the terms of reference for that advisory circle.

The meeting was like no other I've attended. I've not sat in on too many conversations about building terms of reference but it was grounded in partnerships and collaborations. Together the advisory circle officially named itself the Ontario Caring Advisory Circle, OCAC is the acronym, and they defined their mandate, which I want to read to you. It is, "The Ontario Caring Advisory Circle demonstrates leadership by guiding the identification and development of culturally appropriate resources to support indigenous residents in long-term care."

The other important piece of that inaugural meeting was that we defined a consensus decision-making model, giving all members an opportunity to speak at all times and contribute to decisions. Given that most of our meetings will be via teleconference, we felt it was really important that we adopted a model where there was an opportunity for everyone to speak at all times and not the type of meetings where two or three people speak and the others are simply nodding in the background. We defined that very clearly. That was very effective in bonding us and feeling coordinated in the work moving forward.

We are six weeks from that inaugural meeting. We've had one teleconference, an invitation to speak in the House of Commons, and we've also been asked to consult in some research projects for another organization. We feel the need is there and that the resource of the circle itself may be the most valuable resource in the spectrum.

At this time, I'd like to pass to Teresa and Vincent, both members of the Ontario Caring Advisory Circle. Teresa is going to speak from her perspective of this experience, and Vincent is here to support her.

● (1540)

Ms. Teresa Doxtdator David: Greetings to the chair and members of the Standing Committee on Indigenous and Northern Affairs. Thank you for the invitation to speak with you today.

I have been asked to share some experience of working in long-term care in a facility that is one of very few situated in an indigenous community. As a supervisor in a 50-bed long-term care facility, my role over the past 17 years has varied from that of ward clerk-receptionist to admin assistant to activity aide, to my role now as rec and leisure supervisor.

If you asked for the one decisive factor that I have learned from my experience, it would be this. Time is the one feature that residents in long-term care have an overabundance of during their stay, whereas in contrast, staff members do not have enough time to provide the quality care that residents deserve.

Time as a concept is organic to indigenous peoples around the world. They survived in a natural environment now commonly known as Mother Earth. As well, there are plenty of published anthropological papers and textbooks that indicate how the original peoples survived and appreciated the land they lived on.

Consider in contrast your own concept of time. Do you put a value to it, do you use it wisely, or is it something to be conquered, with a winner and a loser in the end?

While I cannot speak for other indigenous peoples and communities, my insight is gleaned from a retired RPN, whose career started in southern Ontario, then moved to Sioux Lookout, and ended up in British Columbia where she retired on Vancouver Island, who happens to be my mother.

The Thanksgiving address, or the *Ohen:ton Karihwatehkwen*, is the central prayer and invocation for the Haudenosaunee, also known as the Iroquois Confederacy or Six Nations—Mohawk, Oneida, Cayuga, Onondaga, Seneca, and Tuscarora. It reflects the relationship of giving thanks for life and the world around them. The Haudenosaunee start and close every social and spiritual meeting with this address, sending greetings to the natural world and asking for everyone to use a good mind while business is conducted. In one Mohawk community, an individual was known and recognized to recite this Thanksgiving address every sunrise, to ensure that everyone would see another day.

Indigenous peoples are credited with being the first scientists: geneticists creating hearty seed, my ancestors; physicists, quantum theories abound everywhere now; and mathematicians. The activities of the family evolved around the changing seasons. Faith keepers and knowledge keepers continue to educate and encourage their people today.

Included in the teachings are the rituals or community practices that occur at various times of the year. It is the time of expressing thanks to the natural world, the spirit world, and the Creator, with an appeal to maintain the health and prosperity of the nations. Depending on how the indigenous culture lived on the land—as hunter-gatherers, fishermen, agriculturalists—their calendar of activities was centred in the natural world in order to survive.

I was a participant in a fish study project years ago. Our funding came from Quebec. We were interrupted because, when the geese arrived, our researchers and our goal in the project—everything—stopped. The village said, "You know, nothing is going to happen for the next two weeks, because everyone has gone hunting."

Community and family was everything to indigenous peoples. Unfortunately, this very important cycle of tradition and teachings has been broken by residential schools, beginning in the early 20th century, and by the sixties scoop, during which children were taken from their families and placed with non-native foster families, to various degrees of failure.

Historically, when nursing homes were first established in western culture the residents played an active part in the operation of the home by working at various jobs in order to pay their way. The residents did chores common to every household, which required everyone to pitch in and share the workload to ensure survival, to have a sense of self-worth, and to contribute to their community. Later, these facilities became dreary places, identified as places where you go to die, until the restorative care incentive was introduced in 2010.

Recently, residents were interviewed and participated in a food service satisfaction survey in the home where I work. A lifelong farmer asked, "What happens to the food I don't eat? Where does it go?" When he learned that the food was thrown away, he remarked, "We should have pigs. Feed them the leftovers and then slaughter them in the fall." Does this sound like a person just waiting to die?

● (1545)

Anyone over 18 years of age can be admitted into a long-term care facility. Taking care of indigenous residents is not limited to the frail elders. With the breakdown of the family unit, poor lifestyle choices are made by individuals who would benefit from a holistic treatment. Most traditional medicine ceremonies and teachings consider the whole person when trying to help. This includes the social, physical, emotional, spiritual, and intellectual parts of the person. When their minds and bodies have not had the opportunity to deal with the trauma inflicted by generations of abuse, they may be diagnosed with diseases that are directly related. Unfortunately, some health services are geared to preventive measures for community members, and requests for residents living in long-term care can be ignored.

Growing up and being told "what happens in this house stays in this house and no one else needs to know" leaves caregivers and family members struggling to keep their loved ones at home. It is a shame to ask for help. It is admitting defeat.

The health care team in long-term care homes involves the health professionals and the family members working together to educate and provide the resident with the care and treatment he or she desires. For example, in my experience, an elder female resident was not feeling well and asked for a cup of hot water. In reality, she wanted to make a cup of cedar tea, but did not have the resources, ability, or autonomy to ask for what she wanted. Her mother was a well-known, respected herbalist and healer. This was a lost opportunity to learn about herbal medicines.

Fifty years ago, as part of a church youth group, I took part in a Christmas visit to a nursing home in an indigenous community. My mother had learned that a childhood friend and neighbour was now living there, and she tasked me with finding him and reading a letter to him. Because I was 11 years old, this was not something that I wanted to do. I remember being taken to a dimly lit ward with two rows of metal frame beds lined against both walls. As I approached the sleeping individual lying in bed, the staff member called out, "Percy John, you have a visitor", and promptly left. Not knowing if he was asleep or not, I read the letter out loud, never taking my eyes off the pages. In the letter, my mother reminded Percy who she was, indicated who I was, shared some childhood reminiscences, and ended with wishing him a merry Christmas. Relieved to have accomplished this task, I looked up finally to see great tears rolling down wrinkled, withered cheeks. Not knowing what to say, I left the letter on his bed and left.

That same experience could have happened last week, as the residents I now care for exhibit the same signs of loneliness: sitting near the front doors, waiting for someone to come to talk to them.

The newly formed Ontario Caring Advisory Circle on indigenous long-term care was created in April this year at the birthing centre in Toronto, Ontario. The individuals who came together for this session have made their own two- or three-year commitment to the group. Nine individuals started a journey at the beginning of that day. By the end of the day, a team—including the two absent members being "voluntold"—agreed to work together and made a schedule to meet in the coming months.

Indigenous culture celebrates a new life with family and friends. An individual who chooses to die in his own bed is surrounded by family, and they are supported spiritually by community. When a cycle of life reaches its end, this time is also marked with what society is now calling a celebration of life, where family and friends come together one more time to honour the deceased.

For the nursing professionals, who are basically scientists, death is considered a failure. The gap between the generations in indigenous families now has an opportunity to close with information and guidance. Instead of young people being afraid of the frail elders, especially when the elder no longer lives in his or her own home, generations are encouraged to share stories and eat a meal together, a universal expression of love. The communal celebrations could be hosted by the indigenous residents in the long-term care residence to accommodate those family members and community.

● (1550)

The backgrounds of the OCAC members are varied by their geography, nationhood, and experiences. However, their goal is the same: to demonstrate leadership by guiding the identification and development of culturally appropriate resources, to ensure that indigenous culture is recognized as a valuable aspect of health care in long-term care, and that the tools and resources are identified to the health care provider.

Is it okay to end with a Bible quote?

I would like you to consider this, and don't forget I'm from the seventies:

> To every thing there is a season, and a time to every purpose under the heaven:
> A time to be born, and a time to die;

Mr. Vincent Lazore: I'll finish:

> ...a time to plant, and a time to pluck up that which is planted;
> A time to kill, and a time to heal; a time to break down, and a time to build up;
> A time to weep, and a time to laugh; a time to mourn, and a time to dance;
> A time to cast away stones, and a time to gather stones together; a time to embrace, and a time to refrain from embracing;
> A time to get, and a time to lose; a time to keep, and a time to cast away;
> A time to rend, and a time to sew; a time to keep silence, and a time to speak;
> A time to love, and a time to hate; a time for war, and a time for peace.

We'd like to thank you for your attention today.

The Chair: That was a very powerful statement. Thank you for that.

Now we're going on video conference. You have up to 10 minutes for your presentation.

Dr. Bonita Beatty (Professor, University of Saskatchewan, As an Individual): The key issue here is addressing long-term care on reserve. I come to this presentation through both research and experience.

I grew up on a northern reserve. I still have a home on the northern reserve and I do a long commute to where I work.

I've done my Ph.D. on health care services and looking at first nations' health care services and its development. When we took over health transfer, back in the early nineties, we saw there were a lot of elderly people. When I speak of the term elderly, we know that the pension age of 65-plus is considered senior and people normally look at it as 65. Some now, due to the generally poor health status on the reserves, use 55 years or some even younger.

What we were finding was that there were a lot of elderly people. I like to use the term elderly or elder. They are mostly in their seventies, but particularly in their eighties is when they become the most frail.

At that time, we were on the development edge of developing home and continuing care services and what that would entail. My experience was that, in developing that, I never dreamed that I would one day come to use those very same services for my own parents. You just never think of those things, but I did. Over the past 10 years, both parents have gone and passed away in their eighties, along with my aunts and my uncles. What I have found, with my own community and having worked with the provincial first nations health organization as well, is that a lot of the same issues that my parents faced and I faced in our care of them were the same experiences that first nations families all over had. Also, there were other non-indigenous families as well, who experienced similar types of challenges, particularly when their loved one ended up with dementia and things like that. This is a common thing for all of us in Canada.

I am speaking to you from the Treaty No. 6 territory, which is in Saskatoon. My own band, the Peter Ballantyne Cree Nation, also come from a Treaty No. 6 territory. It's the treaty with the medicine chest clause that we have interpreted as the holistic comprehensive health care. We are looking at the care of the person—before they're even born, to the time they pass on. We talk about the seasons of life and those are the necessary seasons that we all have to go through. However, as citizens of this country, we should all expect to be cared for, to go in dignity, and to be treated with respect.

Those are the end goals that I'm looking at. I'm just going to go through this presentation, particularly to promote the need to build long-term care homes on reserves that are properly subsidized, that can be maintained and sustained, and to ensure that the elders we have can access sustainable long-term care facilities in, or at least near, their homes and families.

We just have to look at the media to look at the stories with elders who have been placed in Ottawa from Nunavut, for example. People are placed from my own isolated northern communities into the urban centres and whether it's people who don't understand their culture.... Even with well-meaning health professionals, they just don't understand and can't relate and communicate and work with families in a way that is respectful and is also most effective in terms of care.

● (1555)

In placing our first nations elderly, one of the things we have to consider is that the demographics are growing. The indigenous population is growing overall. Certainly what we've found now as well is that the seniors population is growing. In 2011, the estimates through Statistics Canada suggested that there is about 6% of seniors in the 1.4 million aboriginal population. By 2016, that had grown to 7.3% of the total 1.7 million. It's continuing to grow. Some projections estimate that, by 2036, the seniors population is going to double or more than double.

Obviously, the situation is not going to improve unless there are some dedicated resource investments and dedicated strategies to address that continuum of care on and off reserve, because basically you're trying to address that person, that individual, and that individual is not ever alone. They come in a package, a family package, and they also come in a first nations community package. With that, there are a lot of traditional values that are unique and distinctive. There are regions across Canada; we're not all the same. That's one of the things when you're dealing with culturally appropriate programs and services and their development.

Sometimes people assume that everybody is the same, but they have different backgrounds. They have different languages and they come from different areas. Their experiences as children are also the same, although they might have had experiences with.... This is, I guess, the tragedy of it. A lot of these elders that even go into dementia may have gone through the residential schools system or they might have gone through the TB sanatorium system that we're finding out about now. They also might have gone through some of these Indian hospitals that they recall. There are a lot of areas where, as children or adults, they might have experienced trauma that comes back along with other things through the years of life.

These are the things that we have to consider even as families looking after our loved ones. I know that the one question that was asked.... I have done a lot of studies in long-term care research and program development research as well as caregiving research. I go to these research things not because I'm asking a question, as most researchers would do, but because it's been placed before me by the communities and people whom I work with and it's become a need that needs to be addressed. We're just trying to find out as much information as possible about it, which is what research is, being informed to be able to make the most balanced and cost-effective and quality type of decisions.

Some of the common themes I looked at, one of the questions that came out, especially with the seniors, concerned the frail elderly when they're feeling vulnerable. I talk to the most vulnerable population, not just the elderly who go into long-term care facilities but also disabled youth sometimes. Nonetheless, they're vulnerable populations and they have things, as somebody mentioned—loneliness, isolation, abandonment. One of the questions that comes out over and over again, and I've heard in visiting elderly and my loved ones as well, was "Who will take care of us when we get old, when we're no longer able to help ourselves?".

It's a question all of us ask, I suppose, but when you're at a vulnerable season, that becomes a time then to gather the resources and bolster the foundation that will help provide for them, so that they're well cared for until they go on.

This is one of the reasons I wanted to come here, the current status of continuing care services. Typically in Canada we refer to them as a basket of services. We know them to include home care, long-term care, respite, palliative, but for reserves, that basket is particularly small. The current stats show long-term care on reserves is fragmented. Some first nations are very fortunate to have long-term care facilities. It's not a common thing. I know in Saskatchewan we have maybe three for a population of over 90,000 indigenous people. You have to look at that.

● (1600)

The current status of long-term care in the western provinces is much the same. There's no dedicated funding for the development of these facilities on reserve. There are no subsidy programs, like the provincial and the territorial programs might have, that ensure sustainability and maintenance of these facilities. That all has to do with jurisdiction and the policy directions that government has taken.

One of the other things is the whole affordability issue, with provincial facilities based on various income-testing formulas. Pensions are the most common form of income for first nations. For example, in our case, Standing Buffalo First Nation in southern Saskatchewan is really struggling at the moment. It houses a 22-bed facility, and it also deals with disabled youth in that same facility, so there are a lot of issues there. We've been working to try to address that.

The long and short of it is that with the rising issues involving first nations seniors care, a national strategic plan is definitely needed, one that envisions long-term care on reserve as part of a compassionate and seamless health care continuum of services that places the seniors and their needs first.

That is it.

● (1605)

The Chair: We're going to go into rounds of questioning. I remind members to be sure to indicate to whom you want to ask the question.

We'll begin the round with MP Dan Vandal.

Mr. Dan Vandal (Saint Boniface—Saint Vital, Lib.): Thank you, Madam Chair.

I want to begin by thanking all of you for your presentations.

We only have seven minutes, so I'm going to go quickly. First, I'll go to Teresa Doxtdator and Vincent, whoever wants to answer the question.

I want to ask about your interactions with the federal government. I know that we have a first nations and Inuit home and community care program. First, do you interact with that in terms of...?

Mr. Vincent Lazore: In a roundabout way, we do through our director and council.

Mr. Dan Vandal: Can you tell me about that? Can you tell me what those experiences have been like?

Yes, start with that.

Mr. Vincent Lazore: I'm relatively new to the administrator position, so I really haven't had much experience in that as of yet.

Mr. Dan Vandal: Teresa, can you...?

Ms. Teresa Doxtdator David: I come from Akwesasne. That should say it all. MCA is federally funded, so our elected council is constantly—I don't know the correct word—finding funding. Mike Mitchell is the greatest advocate for the community. He's one of the more vocal spokespersons for our community. We actually met with him to learn about the beginnings of our home, Tsiionkwanonhso:te.

Mr. Dan Vandal: Excuse me. Mike Mitchell is the...?

Ms. Teresa Doxtdator David: He's a very respected, well-known politician from Akwesasne. He is retired, but he now works in Ottawa for the assembly of chiefs.

Mr. Dan Vandal: Okay.

Ms. Teresa Doxtdator David: We definitely have our finger in the pie. I don't think the relationship has ever been adversarial.

Mr. Dan Vandal: Okay, I'll come back to that.

Tammy, the RIA published a study entitled "Using the Labyrinth for Spiritual Practice" in 2011. I'm not sure if you were there then.

Ms. Tammy Cumming: I was not, no.

Mr. Dan Vandal: Are you familiar with this report?

Ms. Tammy Cumming: I know of it, yes. I'm not familiar with that particular body of work. We have, I think, 11 research chairs now with the organization, so there are a lot of bodies of work. Sometimes we identify those resources to spread within long-term care if they're specific to long-term care, and sometimes they're not relevant. My responsibility is particularly this program that the government has funded.

Mr. Dan Vandal: This program being...?

Ms. Tammy Cumming: The Ontario Centres for Learning, Research and Innovation in Long-Term Care. It's a Ministry of Health and Long-Term Care-funded program that's been funded for the last six years. We just got renewed funding last year. It's base funding from the Ontario government, and this work falls within that.

Mr. Dan Vandal: Okay. I know you've probably already spoken about that a little in your presentation, but can you give us the highlights again?

Ms. Tammy Cumming: Of the program...?

Mr. Dan Vandal: Yes. What supports do you provide?

Ms. Tammy Cumming: It's a wide range.

An example of some of the work that we do is this particular work supporting indigenous culture and long-term care. We have a program supporting cultural diversity, which is ethnicity, gender, and sexual orientation resources. It helps support homes to deliver individualized care.

We also do various programs. We have educational programs. One is living classrooms, where we train personal support workers and practical nurses in long-term care. There's a huge shortage of staff in long-term care, personal support workers in particular. It's important to train them and to expose them to long-term care. Partnering with colleges to deliver care is an example of an education program that we offer. We have lots of different educational tools.

The idea is to identify resources that are out there so as not to recreate things that are already out there, and then to develop ones that the sector identifies as being needed. That's the purpose of the program.

Mr. Dan Vandal: Okay.

I have a question for Bonita Beatty.

You've been researching long-term care. Have you done any research on the importance of home care and keeping people in their homes from an indigenous perspective?

● (1610)

Dr. Bonita Beatty: Yes, absolutely.

As I said, indigenous seniors tend to fall into three areas during their care and continuing care life. One is at home. Another is during the transition, when they're moved to a long-term care facility. The third is at the long-term care facility. Each of those steps in that journey has specific needs. Often, home and continuing care is kind of a limited program on reserve. It's only offered for the work-day hours. There are no evening hours or weekend hours covered for it.

Mr. Dan Vandal: Is there nothing after office hours or on weekends?

Dr. Bonita Beatty: No.

What came out in our caregiving research is that this is oftentimes when they need the help. Fortunately, in our case, we have 24-7 health clinics. Primary health care nurses are on site, so they're the ones who usually get called when a medical emergency arises. We also have ambulances in some parts of it.

For the isolated communities, whether they are three or four hours away from the hospital, for instance, it's very difficult for them to be able to keep their people at home. By and large, in almost every bit of literature that you'll find anywhere, both for indigenous and non-indigenous people, they want to stay at home. They want to be with their families and they want that support. Caregivers want that, too.

Mr. Dan Vandal: I have one more question.

Our government understands the importance of home care. We threw in an extra $6 billion for the provinces. I seriously doubt that any of that will trickle down to the reserves, however.

Dr. Bonita Beatty: No.

Mr. Dan Vandal: I only have about 20 seconds.

Do you have any advice to give the government? What should we be doing more of, or what should we be changing?

Dr. Bonita Beatty: You need enhanced home care programs. You have no palliative care. There's no respite care, and there are no additional hours for the home care. Home care addresses chronically ill people, who are not just seniors. There's a whole pile of people with chronic health issues, and seniors tend to get isolated sometimes. You need a focused, strategic plan within the home and continuing care program that targets the seniors so that they're a focus and so that program gets enhanced. There's no getting around the enhancements. That's only to make it comparable to what the province has.

Mr. Dan Vandal: Thank you.

The Chair: Okay.

Questions now go to MP Kevin Waugh.

Mr. Kevin Waugh (Saskatoon—Grasswood, CPC): Welcome, all.

I'm going to continue with that topic that we're talking about—elders who want to stay at home.

To what extent do the current federal programs for home and community care allow elders to remain at home in their communities?

We're going to continue with you, first of all, Ms. Beatty, because I think you have a connection with the Peter Ballantyne Cree Nation. You were talking about that.

What current federal programs are helping? Are they helping?

Dr. Bonita Beatty: In Peter Ballantyne, we only have the home and continuing care. We had done a lot of work trying to get a long-term care facility on reserve, even a downsized one, so that we could maintain some assisted-living facility or something like that, because there's no support funding, no operational funding, or maintenance funding for that within the policy envelope or the budget envelope within that home and continuing care package. Facilities are part of it. You keep people at home or as close to home as possible.

The other thing is the non-insured capital benefits. They're limited in what they provide as well. A lot of the at-home maintenance and renovation of access, even the rails on the houses, those kinds of things are not possible. Families are really struggling to maintain their elderly at home with even the types of beds that an elderly person needs to pull themselves up, or even the lifting things, especially when they're immobile. There are a lot of issues.

As I said, dementia care is an area that really needs to be looked at, because it's growing in our communities, and it's really at that frail elderly stage. Even in our band, just within our community, there are four of them in the personal care home who we would have wanted to maintain at home. It's usually the last resort that puts people in long-term care home facilities away from home. If you look at the Canadian stats, that's also what happens with Canadians in general. People generally don't go to these long-term care facilities unless it's a last resort because they're medically at risk. The same with—

● (1615)

Mr. Kevin Waugh: Yes. I'm going to go to Teresa now, if you don't mind.

Can you comment on this? You have 50 beds, I see. Can you talk about the federal programs for the home and the community? Do you get any of that to keep your elders at home?

Ms. Teresa Doxtdator David: I really don't have knowledge of the administration.

Mr. Vincent Lazore: One of our strengths in Akwesasne is that we have these services. We have home support where they're dealing with 85 to 90 clients right now. We have holistic health. We have all these programs, and yes, they are funded, but one thing we find lacking is training. We're short on nurses, we're short on RPNs, and we're short on PSWs. In order to keep these services going, we need more training for staff to keep them up on the latest whatever. It's just that we need more training.

Ms. Teresa Doxtdator David: If I could add, on the standardization of PSWs, you have PSWs coming to work in long-term care who maybe took a correspondence course and have no real consolidation experience. They get burnt out, and then they're gone. Then we end up with issues of abuse in our homes, so standardization, I think, would be key for the education process.

Mr. Kevin Waugh: Yes. I think we're all learning. Palliative care has just come up since 2015. Mental health is a big issue. We haven't even peeled back the onion on this. These are other issues.

Now, let's just take the federal government. Would you recommend a one-size-fits-all, or are we going to have 10 different ones for the provinces plus three different ones for the territories? How does the federal government get around some of this palliative care that we've talked about, dementia problems, and mental health problems? What recommendations would you make for us to take forward in our report to deal with this? If you don't mind my saying, it's kind of new and we're just dealing with this.

We'll start first with Tammy, if you don't mind, then we'll go to Teresa and then over to Ms. Beatty.

Ms. Tammy Cumming: Are you asking whether it should be provincial-specific or across the country?

Mr. Kevin Waugh: Yes. Is this a one-size-fits-all?

Ms. Tammy Cumming: My sense is no, because the structures are so different within each province for long-term care. That would be my sense. I'm not an expert on how the federal government is funding it. We're a provincially funded program.

I would like to add, though, that everyone wants to be at home as long as possible, but long-term care is inevitable for some people, because they need that type of support. In Ontario, we're desperately trying to improve the perception of long-term care. We have made strides in moving from an institutional model of care to a social model. There's still a lot of work to be done, but there is some incredible care being provided in the province in some homes that are doing amazing work, and the only thing that gets shared are those negative stories.

Yes, giving good quality care is a boring story, because that's what we're supposed to be doing, but we need to showcase those examples because people are so fearful of going into long-term care because they think they're going to be in a hospital.

Mr. Kevin Waugh: Go ahead, Teresa. With the federal government, how would they disburse this money? Is it one-size or are we going to do it differently, 13 different ways?

Ms. Teresa Doxtdator David: Working in recreation and leisure, we're constantly looking for materials. I would be happy with a one-size-fits-all, and then we modify it to suit our needs.

Mr. Kevin Waugh: Bonita, your thoughts?

Dr. Bonita Beatty: Yes, it's similar to the way home and continuing care started. I think you need similar standards, especially on reserve, because this is federal jurisdiction and indigenous governance, so you need to look at the standards of palliative care so that you can provide that on reserve. I think it can have similar standards across the board, and as I said, it can also be made distinct by the providers themselves. We can work with standards.

● (1620)

Mr. Kevin Waugh: Thank you. I'm out of time.

The Chair: Thank you.

Questioning now moves to MP Rachel Blaney.

Ms. Rachel Blaney (North Island—Powell River, NDP): Thank you.

Thank you, all, so much for being here today.

Teresa, if you don't mind, I'd love to start with you. First of all, I want to thank you for your good orientation. I really appreciated the way that you spoke through your presentation. I think it oriented people in a really pleasant and important way.

One of the things you talked about was the story about asking for hot water but actually wanting medicinal tea, and the other thing you talked about was how the elders have a lot of time but the care workers don't have a lot of time. I think those two things intersect in an important way.

I'm just wondering if you have any suggestions or ideas about how to build an environment where that asking for water becomes an asking for the medicinal tea?

The Chair: Are you asking the people in Saskatoon?

Ms. Rachel Blaney: I'm asking Teresa. That's how I started.

Ms. Teresa Doxtdator David: Right now, because of the act, we're task-oriented. We have 20 minutes to provide care to a resident. In our home we have what we call pods. We have one staff member to 10 residents. You have to come in at seven and get 10 residents up and ready for breakfast—washed, dressed, whatever they want. There's not a lot of time for interaction. My role in activities is to try to create cues and tools that staff can use. So if you go in and a resident can't remember the names of their grandchildren, on the wall there may be a cloth quilt with pictures of the grandchildren with names on there. That allows the PSW to ask how so-and-so is doing today, or whether they've heard from them lately, because the PSWs just don't have the time to provide the interaction that's needed.

They also don't have the time to pick up the cues when someone's in distress. We're taught to be aware of pain and to look at the resident's face, look at their body language, but when you have somebody sitting on a toilet, somebody ringing, and then there's an emergency bell, staff assist, and everybody runs. There just isn't time, so this person feels lonely and unworthy.

Ms. Rachel Blaney: Thank you.

Tammy, you talked about the work that you're doing that is Ontario-focused. I'm just wondering if the framework that you're looking at in terms of this new circle is going to be shared across the country. Is there any model for that to happen?

Ms. Tammy Cumming: There's an appetite for sharing resources and ideas across the country, so, yes, we're funded to stay specific to Ontario, but absolutely there are opportunities for a spread. The RIA's mandate is national and global, so that does happen, yes, for sure.

Ms. Rachel Blaney: Would you say there's a little gap maybe in funding in terms of having a federal process to share these kinds of models to make sure we're doing the parts around reconciliation that need to happen?

Ms. Tammy Cumming: Absolutely, yes.

Ms. Rachel Blaney: Thank you.

I'm wondering, though. In the work that you're doing, are you focusing on rural, remote communities as opposed to urban communities, which have very different realities?

Ms. Tammy Cumming: Yes, we do, but there is an increased focus on northern and rural and smaller long-term care homes. You tend to get the bigger homes and the more open homes adapting some of the change. So yes, there's an increased focus on that with the renewed funding.

Ms. Rachel Blaney: Good. I represent a rural and remote riding, and often people from indigenous and non-indigenous communities are pushed to go somewhere else and lose all of their social infrastructure. I think this is something that the federal and provincial governments need to be collaborating on, especially around indigenous issues.

Bonita, I just wanted to say that I read your paper and you mentioned that the nation had actually put together an ideal care management scenario or scenarios. Can you tell us a bit more about that? Have you had any cases that have received that final goal of an ideal care management scenario?

Dr. Bonita Beatty: I wish I knew. It's always an ongoing development, right?

For lack of a better word we looked at something called "blended caregiving". We've overused the word "caregiving", but blended care is when you work with the local health professionals on the reserve. I'm looking at other reserves or rural reserves because that's the area I've done a lot of research in and have experience in.

When you're looking at the situation at home and working with the families of the patients—the clients, the elders—and working with the professionals, at the end they often have to be placed, whether they go on respite for two weeks, whether they are being assessed for long-term care placement, especially if they have something like dementia, or whether they are no longer able to be looked after without medical risk at home. When they leave the reserve in that transition when they are placed, they can't just be plopped in a long-term care facility far away. We all know that.

What happens is that you have to work with those professionals within that facility—those nurses, those home health care aides, and all those people—so families also become a part of that continuum, so that blended care between at home health, the family, the patient, and the long-term care facility off reserve in the city, that kind of relationship building has to occur. That's a case management approach. It's a blended care approach.

What happens is that we always have common meetings. Usually a family—in my case we were always keeping the communication loop open, because you have to know what prescriptions that elder is taking, what doctors they have, all that medical history, and also their background. What background did they have? Are they Cree speakers only? Are they Dene speakers only? Language becomes an important part of it. Their cultural values as well as their beliefs also become important.

A lot of it is really training the health professionals. I was just talking to them a few weeks ago, and that's exactly what they said, "We need to be trained; we need to know the background of those elders who are coming in." We, ourselves, don't even know, as first nations people, where the elders are in the province of Saskatchewan. Even in our own band we had to go looking for them, because right now they are being placed out.

The situation there becomes a matter of blended care and not leaving those people off their reserve and off their home list just because they are placed in a long-term care facility off reserve.

It's all a matter of linkages. I think that has worked in several key instances now, so we're continuing to work with it.

● (1625)

The Chair: That's wrapped up your time, just about.

We are moving to MP Mike Bossio.

Mr. Mike Bossio (Hastings—Lennox and Addington, Lib.): Thank you, Chair. I know I only have two minutes.

I have one question. We were very fortunate to hear from Grand Chief Abram Benedict last week. We also heard from Chief R. Donald Maracle from the Mohawks of the Bay of Quinte. I know right now they are in the process of wanting to bring about a long-term care facility for their community, actually for the surrounding region itself.

For first nations such as the Mohawks of the Bay of Quinte and others, what do you consider the most important factors and gaps to overcome to successfully attain and then operate a long-term care facility? That's to Ms. Doxtdator or Mr. Lazore, either one of you, whichever one feels comfortable answering that.

Mr. Vincent Lazore: I think an important aspect of that is to make sure there's a 20-year plan and a 25-year plan. Then, have funding to sustain the infrastructure. Buildings age, and then there's no money to repair. That's what I think is important, in order to keep looking into the future, infrastructure support.

Mr. Mike Bossio: In the optimum ratio of support workers to patients, Teresa, I kn you mentioned that this is a difficult area. What would you say the optimum ratio should be? Right now you said it's 1:10.

Ms. Teresa Doxtdator David: In our home it's 1:10, and we're fortunate. If you go to a larger home, it's less than that.

Mr. Vincent Lazore: It's sometimes one support worker to 20 patients.

Mr. Mike Bossio: Do you think 1:10 is a manageable ratio?

Ms. Teresa Doxtdator David: Yes.

Mr. Vincent Lazore: It's manageable, but it could be improved due to burnout, due to shortage of staff.

● (1630)

The Chair: That's good to know.

Mr. Mike Bossio: Thank you. I wish I had more time. I have a lot of other questions.

The Chair: Thank you so much for coming out. We appreciate it. *Meegwetch.*

We'll take a short break and then reconvene with our second panel.

● (1630)

(Pause)

● (1630)

The Chair: Welcome, everybody, to our panel. Today we're talking about Alberta, and earlier about Saskatchewan and Ontario.

We have an hour to discuss long-term care. We have folks on our video screen who are looking much more HD than Saskatchewan was. That's what we were laughing about. You're looking very good. You'd never know it's snowing in Alberta. We have two live people here in Ottawa, and we're very happy to have you too.

We will start with the folks on our video conference, and then you can figure out how it goes after that. At the end, the live people here will conclude.

Normally we give you 10 minutes, but if you take a little longer, we'll be liberal about it because we have three groups in front of us.

Go ahead.

● (1635)

Mr. Jeff Anderson (Chairman, Fort Vermilion and Area Seniors' and Elders' Lodge Board 1788): Thank you, MaryAnn, and good afternoon to everyone.

My name is Jeff Anderson. I am the chair of the Fort Vermilion Seniors' and Elders' Lodge Board 1788. With me on the telephone is Chief Rupert Meneen, chief of Tallcree First Nation, a critical partner of our board, and sitting before you is our treasurer, Mr. Bill Boese; and Natalie Gibson, our researcher and adviser.

It is absolutely an honour to address the Standing Committee on Indigenous and Northern Affairs on the important topic of seniors and elders care.

For over 10 years, the community of Fort Vermilion has actively advocated for a designated seniors live-in care facility in the Fort Vermilion area. We wish to advise of the long-term, unmet need for seniors and elders care beds in the Mackenzie region of Alberta, especially when considering the needs of one of Canada's fastest-growing demographics, the indigenous population.

Our board and first nation partners are requesting that the Government of Canada work with the provinces to meet the needs of those in rural, remote, northern areas that are under-serviced. This includes more than just long-term care. It includes support services that affect one's quality of life.

We have all of the studies showing the need, yet nothing has occurred to date.

In 2014, the Alberta government partnered with Mackenzie County to conduct a regional housing needs assessment study. This $100,000 study determined that there was an existing and projected need for an additional 117 to 200 care beds for seniors between the dates of 2014 and 2031 in our region. It was recommended that eight to 13 assisted-living beds were needed in Fort Vermilion immediately, in 2014, four years ago, and an additional 14 to 24 beds by 2031. In 2031, the population of those who will be 65 years and over is expected to increase 123.8%, to an estimated 2,417 persons.

Since 2014, the inventory of 122 designated care beds in the Mackenzie region has changed only slightly, with the addition of four care beds in 2017. Currently, all designated supportive living facilities in the region are 100% full, and the DSL waiting list is up to two years. In addition, the facilities do not recognize the unique cultural diversity of the region. Seniors are forced to stay home longer, or they have to go out of the region for supportive care. As our people are staying in their homes longer, we encounter other challenges.

We also have a shortage of health care practitioners. We have reports of local nurses not having been able to take holidays in the last two years.

In rural and remote regions, health care services are much more difficult to access. Seniors close to urban centres can hail a cab to go to buy groceries, or a handi-bus to reach a doctor to refill a prescription. In our remote communities in northern Alberta at times, seniors can't even call 911 in an emergency due to a lack of cellular service.

As a group of passionate volunteers, we have formalized the Fort Vermilion and Area Seniors' and Elders' Lodge Board 1788. In your briefing notes, I invite you to see 10 bullet points outlining our progress.

In summary of those bullet points, the board of 13 includes four appointed directors, one from each of the Dene Tha' First Nation, Tallcree tribal government, Beaver First Nation, and Little Red River Cree Nation. Along with our partners, we have fundraised over $200,000 through a community thrift store and donations. We have had land donated, and we have access to two other pieces of land that we can access to build a facility.

We are working hard to build awareness that the standard formulas used for assessment and tracking of health care needs and supportive services do not work well in northern remote communities. We are now part of a large cross-ministry strategic task force with provincial and federal departments, to discuss the gaps in information and service provision. To date, the task force has met three times on three separate calls, with no outcomes yet.

To give a little understanding of our area, in your briefing notes there, we're part of what's called the Mackenzie County. It is the largest geographic county in Canada, about the size of Prince Edward Island. On page two of your briefing notes, you can see the eastern reserve of Garden River. It is approximately two and a half hours to travel to the St. Theresa General Hospital located in Fort Vermilion.

● (1640)

From Fox Lake, just a little south of it there on your map, via a barge, it's three to four hours to get to Fort Vermilion. High Level, which is towards the left of that little map and in the centre, has a hospital and a proposed lodge with a 25 DSL room project under way. Even with that new facility our needs are far from being met.

The Chair: Jeff, I wanted to let you know that we actually don't have your presentation. It's still in translation. We don't have your map, but we're imagining. We're there with you, Jeff.

Mr. Jeff Anderson: Okay, it looks like this. It's right about here.

The Chair: That's the ticket. That helps a lot.

Mr. Jeff Anderson: I'm sorry, MaryAnn. I emailed that out to Mike this morning.

The Chair: Keep on going. You have another four minutes.

Mr. Jeff Anderson: I thank you for that. Actually, your timing was impeccable. That was the end of my piece for now. I'd like to hand it over to Chief Meneen. He had a few words he'd like to say.

Chief Rupert Meneen (Tallcree First Nation): Good afternoon, all. Thank you, all, for giving us this opportunity here today.

My name is Chief Rupert Meneen. I'm from the Tallcree Tribal Government. I have been part of this group for the last 10 years, working on this culturally inclusive facility that we're talking about.

I'm one of the four chiefs who form the North Peace Tribal Council, which includes the Dene Tha', Tallcree Tribal, Beaver First Nation, and the Little Red River Cree Nation. We represent a population of approximately 7,500 on reserve and almost 4,000 off reserve, many living within the Mackenzie region, and including the Métis population. Over 40% of the Mackenzie region is indigenous.

We have a dire situation in the north. We have elders who are in overcrowded homes and are not being afforded the opportunity to live out the rest of their lives in a place where they don't have to cook or fight for a bed to sleep in. They do not and will not move into a facility with unfamiliar surroundings that is out of their home region and away from loved ones.

We have elders in long-term beds in our hospital because there are no supportive living beds for them. Our elders and spiritual leaders are respected in first nations' communities, and I feel that it is my job as a chief to do what I can to make sure they are treated with the respect that they deserve.

It used to be that the younger generation would care for our elders, but now with the social crisis around addictions, opioids, housing shortages, and unemployment it has created an environment where the younger family members can't care for our elders.

We think it is important for this standing committee to look at the broader picture of the actual needs for care within our region. Long-term care is one component. Another is home care. Another is housing. I am in support of a culturally inclusive facility right now based on our infrastructure. The location is best-suited to be within Fort Vermilion. We live in rural and remote areas where health care is challenging, so health care includes both the facilities and care prior to entering the health care system.

Our life expectancy is lower in the north than in many other regions due to poor socio-economic conditions, and residents need seniors' lodges 10 or more years earlier than the non-indigenous population. The reason we are getting overlooked so much is that the data between Alberta Health Services and Health Canada is not captured or tracked in the same way, and the funding formulas are largely focused on urban populations.

What we want and what is needed right now, number one, is for the Government of Canada and the respective provincial government to get on the same page in gathering and tracking data in rural, remote, and northern communities. Number two, there should be several business cases, including one in Fort Vermilion, that review public-private partnership to deliver culturally inclusive health services. Number three is to build capacity, train the people needed to build the facilities and to staff, manage, and support seniors' and elders' care.

Again, I want to thank you, all, for allowing us to present on this much-needed facility. I thank you again for allowing us this time with you.

● (1645)

The Chair: Thank you. *Meegwetch.*

Now we're over to the two of you.

Natalie.

Ms. Natalie Gibson (Research and Advisor to the Board, Fort Vermilion and Area Seniors' and Elders' Lodge Board 1788): My name is Natalie Gibson.

I'd like to reiterate what both Jeff and the chief said regarding the data. The Mackenzie regional housing strategy was done. Our needs assessment was done four years ago. It stated there was a need for 117 to 200 beds in the region, and it still continues at this stage, four years later.

When we started looking at the data, we noted that Health Canada and Alberta Health Services data were different in measuring, and as well, the Statistics Canada versus municipal affairs data for the region were out by as much as 2,000 people. This comes into consideration when you use the funding formulae that are based on population, and also the indigenous population is measured in quadrants of three age brackets versus seven to 10 in the general population.

The big statement here is that we don't know what we don't know. When we get asked by provincial and federal governments how many beds we really need, to look at a flexible model in today's market, we don't really know.

The other big issue, as Jeff mentioned, is workforce in the region. Approximately 40% of the population—where we can track the numbers—is in long-term and supportive care and maintenance. As far as the 13 reserves or four first nations are concerned, we have very little data to go on to amalgamate as a region. As the chief mentioned, whether it's on reserve or off reserve, we think as a region. In the Métis population, there are more than 1,000 indigenous people living within the community and, of course, the community of Mackenzie as an area as a whole.

I have a lovely little table to illustrate, when you do find the briefing notes. That gives an indication that there are 450 to 500 people already in home care. Within-home care is the next step to maintenance in the health care system. It's in that particular area where we're short of staff—health care aides, nurses in general. Also, when it comes to the responsibility, we've met with the province on more than one occasion, as well as here in Ottawa, and we find that this particular lodge is being passed from person and jurisdiction to jurisdiction. As the chief mentioned, we need to partner on this, so we're looking at innovative ways for a public-private partnership to give the opportunity for seniors and elders to age gracefully in place.

Mr. Bill Boese (Treasurer, Fort Vermilion and Area Seniors' and Elders' Lodge Board 1788): Hi. My name is Bill Boese. I guess I'm the story they're talking about. We moved to Fort Vermilion in 1963. I grew up there. My parents started a farm up there. When they retired, they had to go south for health care reasons. With no options up north, they ended up in Red Deer.

I don't think a lot has changed. Several facilities have been built up there since then. They're full. They're extremely hard to get into and it's still happening. The aging parents of a number of my friends are still moving away to live in care facilities. That's what happens up there.

There are dozens of stories such as my family's, and I expect an even higher number on the first nations. They don't want to move away from their family, or their cultural roots as well.

You don't have our notes and we have a few things listed here, so I'll read them out in conclusion.

We recommend the establishment of northern metrics with quantitative and qualitative data that truly reflects realities in northern areas and its specific needs, to promote a sustainable, culturally and gender-sensitive designated senior living facility, especially for the numerically dominant local first nations and Métis people. The Government of Canada should work with their provincial counterparts to actively collaborate to standardize the core datasets and ensure accurate regional data by including northern metrics with a focus on unmet needs and underserved populations.

For the development of a Fort Vermilion and area culturally inclusive DSL facility, a cross-ministry partnership task force should develop a business case with the relevant northern metrics, providing staff with accountability and authority to make decisions in the direction of expanding their circle of influence as opposed to referring responsibilities to other departments. The business case would provide scenarios on a culturally inclusive facility that promotes sustainable, culturally and gender-sensitive DSL facility development, especially for the numerically dominant local first nations and Métis people. The business would include innovative public and private partnership options and incorporate employee retention and attraction strategies.

We would like to be one of the 100 recipients that Mr. Keith Conn referred to in the May 24 meeting in which he mentioned a grant-like arrangement for a 10-year period to respond to community needs based on their priorities. The business case would consider economic development options within the facility and/or with service provision options. The business case would include options to provide the right level of service at the right time for the right patient.

Address the gaps in information data. We need a solution to resolve the immediate need for a DSL facility in Fort Vermilion.

Third, to build capacity in the health care workforce, there is a strong need for federal and provincial governments to increase commitment for training and outcomes in rural and northern regions. Employment attraction and retention can link to entrepreneur development by privately providing services.

We have a good example of that up north right now where an entrepreneur has gone out and is building ready-to-move houses. They're being built by people on the reserve to be moved back onto the reserve. That's a really good example of what could happen if we can do it.

Additional training can support first nations' capacity to efficiently deliver health care in their communities.

Lastly, the quantitative direct benefits would be datasets relevant to the region; strategies to incorporate traditional and non-traditional partners into a sustainable facility; a sense of local ownership, employment, and entrepreneur development opportunities; a sense of indigenous pride by incorporating inclusive values in the facility and study development; and promotion of aging with dignity and the promotion of the Fort Vermilion and area DSL facility as a model for other isolated or remote rural northern Canadian communities.

In addition, opportunities exist to develop partnerships with the private sector for corporate funding and branding, and with regional community colleges offering skills training in the required jobs.

● (1650)

The Chair: That's very good. Thank you very much.

We're going to start the rounds of questioning. Again I remind you to direct your questions to whomever you wish to speak to.

MP Will Amos will start us out.

Mr. William Amos (Pontiac, Lib.): Thank you, Madam Chair, and thank you to all our witnesses. This is a really great set of presentations. It's helping us understand some of the needs, particularly in more isolated communities.

Chief Meneen, what are you hearing from elders in the community? What do they share with you about the needs, about their needs as they age, not just in relation to the hard infrastructure that might be necessary but in terms of the way they want to live, the way they want to age in their communities? What's your view on the best way that the federal government can support that?

Chief Rupert Meneen: I think in our culture our elders love being around their grandchildren and their children and just being a part of their family and included in everything that goes on. I think that having to move away from our communities to be two and a half or three and a half hours away where they're not part of the family anymore.... As first nations we are brought up to be one big family, so I think if they can be near home, where the parents, children, and grandchildren can still visit and be part of that, then as the elders age, they age gracefully.

I think it is important, from what they are telling me, that they be in a culturally inclusive facility that includes foods they like and where they can be part of a group of people who they can intermingle with, because our culture is all about talking, laughing, and visiting. That's just the way we are. I think having that facility where they can live their lives out that way is very important and having this group of people around me—with Jeff, Bill, and Natalie—and being able to bring that facility in.... Also, there are the Métis and not leaving people out. Our culture doesn't leave people out. It's including everybody to be part of this.

I think it's very important to have this facility, especially in our north country. We see the big need and our elders see the need, and they push us to be able to try to get this facility happening.

Thank you for that question.

● (1655)

Mr. William Amos: Thank you.

What are some of the things the federal government might wish to avoid doing as it considers the report we pull together? We'll take evidence from all across the country, from indigenous groups from coast to coast to coast. I'm sure there have to be some good suggestions around how you don't want the federal government to move forward with long-term health care if it determines that this is the direction it wants to pursue.

Chief Rupert Meneen: I think what I see as a first nations person and as a chief is that usually we are told how to do something. I have been telling the ministers that we want to be included in the planning and talking stages on what this facility should look like. We want to be a part of it, we want to build it, and you should just let us build it. It will follow whatever it is we need to follow, but don't tell us how to build it. We will build it.

Mr. William Amos: Last week we learned that by 2036 the number of seniors on reserve across Canada could more than double. I can't even imagine what it means to deal with that demographic bulge coming down the pike. How do you see your community dealing with the increasing population of elders in need of that kind of care? I open that question to the others, as well.

Chief Rupert Meneen: From my end, I don't think we have the capacity. We have the shortage of housing. We have overcrowded housing. We need facilities like this to put our elders in where they will be taken care of. We cannot take care of them because of all the issues we have to deal with already. I think it is important that we have facilities like this for our first nations elders to go into and be happy.

Mr. William Amos: Thank you.

Do any of the others have comments on that question?

Ms. Natalie Gibson: Yes, I do, if I may.

I think the consideration is that there are over 12,000 first nations people living within the region, as well as 1,000 Métis, so the trade area population is about 24,000. What is very important to consider in a facility is not only the construction of the facility but how flexible the facility is to fit the demographics in five, 20, or 30 years to be sustainable.

From first-hand experience working with a Métis nation, I know of a long-term facility that was built with approximately 20 units that is underutilized. They also have difficulties in getting nursing staff and in getting individuals to provide security 24-7. As well, something as simple as a food-handling licence has become a bottleneck to how many individuals can be in that facility.

With consideration to what the chief is suggesting on capacity, one of our recommendations is to take a look at training capacity at different levels that you don't usually anticipate with health care when you're doing the long-range planning. We have the boards, the province, and you, but it is very important, as well, to look at another model that is like a public-private partnership that would come in and consider all of those.

Mr. William Amos: Thank you.

If I have any remaining time, Madam Chair, I'd like to pass it off to my colleague, member Robert-Falcon Ouellette.

The Chair: You have about 30 to 45 seconds.

Mr. William Amos: I'll pass that along, then.

Thank you.

The Chair: All right, we're moving on to MP Arnold Viersen.

Mr. Arnold Viersen (Peace River—Westlock, CPC): Thank you, Madam Chair.

Thank you to our guests for being here today.

Bill, for the sake of reference, you said your parents had to go all the way to Red Deer. Can you tell us how far a drive that is?

Mr. Bill Boese: Red Deer would be 800 kilometres or 900 kilometres.

Mr. Arnold Viersen: How many hours would it take to get there?

Mr. Bill Boese: It's a 10-hour drive.

Mr. Arnold Viersen: Jeff, you kept bringing up these "northern metrics". It's a great term. We just need to understand what it means. Is it in terms of measuring how many people need care, or is it in terms of service levels of care? Could you go through that a little bit more?

Mr. Jeff Anderson: Yes. Thanks, Arnold.

● (1700)

Mr. Arnold Viersen: Sorry to put you on the spot, Jeff.

Mr. Jeff Anderson: No, I'm not on the spot.

From the 50,000-foot level on the northern metrics, I'd say what we've understood exclusively over about the last year and a half or two years as we ramped up our last 10 years, Arnold, is that the municipal government has its statistics, the province has its statistics, and the federal government has its statistics. We have been identifying and acknowledging the gaps that are in between all three of those levels.

We want to talk apples to apples. We know that we need, let's say, a 25-unit facility that's level DSL2 for this many, level DSL3 for that many, and long-term care for that many. I want to be able to tell you, Mr. Viersen, exactly what that is, and right now I can guarantee you that the data does not do that.

I can't speak specifically about how far the data is skewed in those gaps. Natalie would certainly be able to help you on that part.

Natalie, do you want to add to that?

Ms. Natalie Gibson: With consideration of the region, as I mentioned, there are four different datasets that are very widely skewed. I know that the province right now is working on capturing the unique aspects of the indigenous population within the region as well as within the province.

In a conference call last week, we had a discussion that 5% error was okay. That's an interesting statement, to me. They're doing their best, but the data doesn't exist. It's 5% of what? Is it of 100 people, 200 people, 500 people in home care? That can substantially influence whether it's a 10-bed facility that is scalable or a 30-bed facility.

I think that the northern metrics.... We know that the indigenous population within Alberta is growing at four times the average national rate, and within the region, six times more than the standard non-indigenous population. We also know that the median age is eight years under the rest of the population. All of these influence the wait-lists and the prevalence of chronic diseases.

When we talk about northern metrics, we're talking about socio-economic conditions. We're talking about the unique cultural blend of Mennonites, Métis, first nations, and indigenous people living within the region. Even the indigenous people living off reserve have been noted as having higher levels of chronic diseases than the general population has. These are all examples for consideration that the formula—here's the box; calculate by number for a funding formula—doesn't fit in a northern, rural, and remote community.

Does that answer your question, Mr. Viersen?

Mr. Arnold Viersen: Yes, I think so.

One of the interesting things, when we're talking about northern metrics, is that a lot of times a metric that works well in Edmonton doesn't work well in northern Alberta. Do you have any examples of that in your particular area?

Ms. Natalie Gibson: With the general population—and Jeff mentioned this in his speaking notes—we don't have apples-to-apples comparisons within the province and federal government.

Alberta Health Services gathers data under the Meditech program. The federal government, indigenous affairs, gathers it under another program. We don't actually have the data that says, here are your wait-lists within this community that are comparable, but we do know that you can't call a cab and you don't have the ability to access medication.

Seniors and elders aren't staying in their homes longer. They're being forced to stay in their homes longer because there's nowhere else to go. If they do go, they have to migrate two or three hours out to Peace River. Once you're on that waiting list, if you choose not to go, which is called "refusal", then you can get bumped back even further for your next placement.

These are all considerations. Note, also, that this is a volunteer board, so they don't have medical backgrounds. Some of the concrete medical data that should exist, and compare and overlap with other data, does not exist at this date, that we're aware of.

Mr. Arnold Viersen: Getting back to Chief Meneen, one thing I've heard about often is that, particularly in the case of private institutions, we've seen some housing boards close down smaller facilities and build bigger facilities in larger centres.

Have your communities had any experience in which elders were living in one smaller facility and have then been moved to a bigger centre because the smaller one was shut down?

● (1705)

Chief Rupert Meneen: No, I don't think we have. There is only one facility right now in the north, and that is in La Crete. That is the only place. We have an elder in there right now.

Mr. Arnold Viersen: Okay.

La Crete, I understand, is a private facility funded by the Alberta government.

Chief Rupert Meneen: I believe so, yes.

Mr. Arnold Viersen: The facility is actually private, and staying there is funded by the Alberta government, as I understand it.

Ms. Natalie Gibson: There are 122 beds within the region, and they are all full.

Mr. Arnold Viersen: Okay.

Is there anything else that you want to leave with us? I have 30 seconds left on my clock.

Thanks.

The Chair: Questioning goes to MP Rachel Blaney.

Ms. Rachel Blaney: Thank you all so much for being here. I really appreciated your presentations.

I represent a rural riding in British Columbia, and some of my indigenous communities are far away. You have to take a boat to find a road to drive on. We certainly understand, then, the particular challenges of accessibility, and also the challenge of so many seniors leaving the community. I have heard some heartbreaking stories about seniors—especially elders with dementia, when they are away from home and losing their English language and going back to their first language, which nobody else can speak—and the challenges of providing care. I really appreciate what you're saying.

I appreciated what you said, Natalie, that we don't know what we don't know. I understand, and we've heard from others besides you that this is a challenge of data, for sure.

Could you talk a little about what the federal government—because that's who you're talking to right now—could do better to help us have a better understanding of what is happening in these communities?

Ms. Natalie Gibson: I believe it's actually multi-jurisdictional. To have it brought to the point of proper policy to make the right decisions, we believe as a group that there needs to be regional, first nation, indigenous population, provincial, and federal governments working together.

One of our recommendations is the standardization of core data, and then allowing for flexibility of adding other data based on regional needs. As you mentioned, we have communities in the north that are accessed by barge, or by fly-in and fly-out service as well.

The consideration is more than.... The word "collaboration" is sometimes overused, so I'll use the word "partnership", in which the core data is agreed to and you say how it will work. From that, you can start better planning facilities and partnerships. There is a region to the south of this particular region in which the municipality has gone ahead and built their own facility. The challenge that we then hear from Alberta Health Services is that they don't know how to operate it, because they went ahead and built it on their own. Now there is a disconnect.

I believe that if it's federally driven or just provincially driven, the same thing will occur. The multidisciplinary task force and team concept, we think, is a good solution.

Ms. Rachel Blaney: Okay. Thank you.

The other thing I heard concerned the amount of money that was spent on research that gave you some meaningful information that would help.

I'm wondering what the barrier is. The research was done. Can you tell me why we are waiting, four years later? What wasn't done, and what is the barrier? What is the gap?

I open it up to anyone. I'm not sure who would be the best to answer.

Chief Rupert Meneen: It's Chief Meneen, here. Can I answer that?

I'll go back a little bit to the question of what the federal government should do. I think the federal government should get busy and start looking at what we've done.

We've created partnerships, we've reached out to Alberta Health, we've reached out to Health Canada, and we've reached out to the federal government. We have brought a group of people together who are more than willing to work together to bring this to reality. I think we've done our part, and I think it's time for the government to look at what more we can do and how can we get this moving sooner rather than later.

I always go back to saying "let's get moving on this". It seems that we've been standing still for a little while, and I think it's time for us to get moving. We've done a lot of the homework and a lot of the work that needs to be done, and I think we need to do something today.

Thank you.

Mr. Jeff Anderson: I would like to back up what the chief is saying, complementing it by saying that a lot of hard work was done and that there's more hard work to go. As Natalie was saying, however, we are still just volunteers. I'm not a doctor. I'm not a nurse. I'm not a statistician. We are just a passionate group of people who know that we have a dire need now, let alone in 2036—or 2031, depending on which dataset you're looking at. If we don't start getting ahead of this now, you're going to have a bigger issue in the future and we really want your help.

● (1710)

Ms. Rachel Blaney: Yes.

I was just part of another study in another committee that was talking about a national seniors strategy and about our needing to start planning, because this population is growing. Indigenous populations were identified as among the most vulnerable populations.

Could you share with me a little bit, as a person who also represents a really remote and rural riding, what the benefits are? I really appreciate the point about the nine-hour drive. I think that's really important to point out. I think that sometimes people sitting in Ottawa don't understand the realities of rural communities and how important it is that we find creative solutions, which I feel you're working on, to create care facilities that will keep people closer to home.

Could you talk a bit about what the challenges are, for you as a group of volunteers trying to move this forward, and how the federal government could do a better job of being more receptive?

Go ahead, Jeff.

Mr. Jeff Anderson: I'm toggling through my mind to decide where to start.

I'll give you a quick little testimony. We have a lady who's very near and dear to us, Marguerite Peecheemow. She's in her mid-eighties. She grew up in Fox Lake. That's one of those communities you have to barge across or fly across to, or wait for the winter road to be built.

She was at the long-term care facility in La Crete, which distanced her by about three or four hours from her core family and friendship group. Because of, if I can be so bold as to say so, a lack of cultural inclusivity, many of us would travel to La Crete to spend time with her in lieu of her family, who were not able to make it because of economic conditions and problems of accessibility.

I'll say it this way. She gracefully broke her hip, and they had to move her into Fort Vermilion. She is actually much happier, because she is a bit closer to her family.

The broken hip came because of overstuffed facilities, according to her testimony, and people not being able to really get to her and look after her. As I said earlier, we have staff shortages. One of our three recommendations is to look at how we can bring more education and training into the area. It's a kind of cumulative effect that has caused people such as Mrs. Peecheemow to sustain hip injuries.

I was talking to one of her family members just a couple of weeks ago. They would love nothing more than to be much closer to Marguerite. The reality is that many first nations might not even have a car, and to be able to see their family, even from two or three hours away let alone nine hours away, can sometimes be an impossibility. In talking to this person, I found they hadn't seen their own mom for two and a half years, and that's just within the region, let alone considering cases out of the region.

I don't know how else to say it to you. I know I'm getting caught up in the passionate anecdotal type of stuff here, but that's what I would like to share on that, Rachel.

The Chair: Good.

We have to move on to another MP, and that is MP Robert Ouellette.

Mr. Robert-Falcon Ouellette (Winnipeg Centre, Lib.): *Tansi.* Thank you very much for coming. I appreciate the opportunity to hear you give your testimony.

I wonder whether we could talk a little more about training. I was working at the University of Manitoba as a professor before, and we were looking at setting up something related to this: elder care in first nations communities.

What are the qualification levels and the difficulties you face in finding qualified individuals who not only have training in a health care profession but also have an understanding of indigenous communities and are willing to remain for extended periods of time and live in and be part of the community?

That's a general question for everyone.

Ms. Natalie Gibson: It has to tie to any continuum of care. Within northern Alberta it's called the north zone. There is a program that was initiated by the regional director, called Grow Your Own, because it was so difficult to get staff or even train staff, even at a health aide or health certification LPN/RN level. Even the more mature students could start part of their training within the region and then had to finish off in the municipality of Grande Prairie, which is four hours to the south. They had to leave their families to finish this, so quite often the apprenticeship programs were not completed.

Grow Your Own was started up, and Northlands College was the partner in that as well. They're trying to work through those solutions, but there are still a lot of gaps. As Jeff mentioned, two RN positions have been posted for two full years and nobody has filled them. In addition to that, there are support services whose specialists fly in and out of the region and are not housed within it on a regular basis, so you may have to wait 30 days for an appointment.

● (1715)

Mr. Robert-Falcon Ouellette: You also just need health care aides sometimes.

Ms. Natalie Gibson: Yes, definitely.

Chief Meneen and the group have spoken about looking at the options for more training on reserve and on settlement within the region to tie to that. The health care aides could assist people to stay in their homes longer. As you noted, a very critical part of any type of long-term care is that it allows seniors and elders to stay in their homes longer.

We were talking on the flight out about the doctors at St. Theresa General Hospital. They are from South Africa, and they fly in and fly out. There are four individuals who shift off, so they are not actually from the community or the region as a whole. They can set the agenda as to what does or doesn't occur in the region sometimes.

Mr. Robert-Falcon Ouellette: Chief Meneen, do you have comments about the training requirements for your community in Fort Vermilion, Alberta?

Chief Rupert Meneen: Yes, it is important that we train our own people, because obviously we're looking at culturally inclusive facilities. You're going to have to be able to speak Dene and Cree. Having our own people, if there is a job waiting for them.... The problem in our area is that our kids go off to school. They get educated and there is no job waiting for them in our area because there is nothing here, so they all end up leaving to go to work somewhere else.

We have been in talks with Alberta Health Services, and our local MLA, Danielle Larivee, has also been supportive of having some sort of training program to be able to house our trainees and put them to work in this facility.

I have graduates next week, and if I were to go to that school and say that I have a job but I want them to take this training at this school for however many years it's going to take to be able to put them to work here, where they could take care of our grandparents—our elders—I think we would have an influx of people coming from all of our region to take care of our elders.

Mr. Robert-Falcon Ouellette: You wouldn't need to fly people in from outside to look after them.

I was also wondering if you could talk a bit about the funding arrangements that are necessary in order to see success in elder care, so that there are reduced costs, we don't have to send people outside of their communities, and they can actually remain at home with their families in a continuum of life and care. Perhaps you could outline how much is needed from the federal government, how much from the province, and then how much from the local community.

How should people actually be working together on these funding arrangements?

Chief Rupert Meneen: We could do it equally between the federal government, Alberta Health Services, and the province. The province has been really open to any conversation we have had with them, and they're really willing to work with first nations right now. I could put a proposal in front of them and say, "This is what it's going to cost. Can you pony up one-quarter or one-half or whatever it is to train people to be able to put them in a facility?" I think they would be totally open to that, and I don't think the price of that would scare anybody.

Mr. Robert-Falcon Ouellette: Ms. Gibson, and then Mr. Boese.

Ms. Natalie Gibson: There are different models for consideration as well. The study that was done in 2014 has valid data that should have been used and never moved ahead. It indicated that almost 35% of the population is low income, and that includes low-income seniors. Looking at ways of staging the levels of income support and how that support is garnered within the region, the opportunity for consideration of research needs to look at those socio-economic conditions.

There are also other models within Alberta and the country. Housing as a Business, HaaB, has created a model where housing is the focus of the project, but you can start a landscaping company, or a deck-building, painting, or roofing company that goes with it, so there is revenue generation as well.

That type of model is the type of model we looked at to ask what there can be when we look at sustainability and employment opportunities, and when we build capacity. Sometimes the statistics for the indigenous population in terms of completion of some of these programs is not the best, and it could be due to not having a driver's licence or due to other conditions. All of these are considerations, not only for a long-term lodge but for a facility itself.

● (1720)

The Chair: Questioning now moves to MP Cathy McLeod.

Mrs. Cathy McLeod (Kamloops—Thompson—Cariboo, CPC): Thank you to all the witnesses, and congratulations on coming together to do what needs to be done for your community.

I tend to believe the federal government should try to be more responsive to community-led solutions. We simply should have some goals. Sometimes square pegs in round holes don't fit that well. If we set some standards around what our goals are and then let the creativity and the flexibility flow, I think that is something we could maybe consider as we talk about what this report will look like.

Someone said it's time to do something. My question is, do what? You said you've been at a standstill. What is the next step that you see you need to do?

Mr. Jeff Anderson: I'll take that one.

I know you don't have the notes in front of you yet, but just to reiterate what Mr. Boese brought up, we see that the next steps are our three recommendations: establish the northern metrics, develop a culturally inclusive business case for the facility, and start looking at building capacity in the health care workforce up north here.

Mrs. Cathy McLeod: Do you actually have land set aside for the facility? Do you have conceptual drawings? Are you at the stage of detailed drawings?

Mr. Jeff Anderson: Yes, we have land that's been set aside; however, we haven't gotten to the level yet of any kind of conceptual drawings and whatnot. We still would like to work out the data to find out exactly what the need is, and what the future need would be, so that design would be more of a long-term focus and not just a short-term gain.

Mrs. Cathy McLeod: I know in British Columbia it was a bit of a different scenario, but I know through what we call B.C. Housing, and maybe through CMHC, they have funding streams to do those next steps in terms of the more in-depth analysis, which is more than just volunteers can do. Is that a path you've headed down yet?

Mr. Jeff Anderson: We are certainly circling around that. CMHC is part of the strategic task force that we currently have with departments from the province and the federal government. We actually meet again tomorrow, and CMHC is at the table, but we have not dove into exactly what they're going to bring yet.

Mrs. Cathy McLeod: I know an initiative in the area I represent was the seed planning money, which really set them into the next step.

I see Natalie wants to jump in here.

Ms. Natalie Gibson: I'd like to add a little more about the task force. The task force started from meetings we had with INAC, employment services in Ottawa, and the ministers of health and indigenous relations in Alberta. It was discussed amongst this group that the task force needs different departments.

In Alberta we have Alberta Seniors and Housing, which is funded by CMHC. We've had three conference calls since then, getting the various groups into the room to see whose portfolio we're supposed to speak to. Alberta Health Services sent us to Health Canada, which sent us to Alberta Seniors and Housing. Now we have the group in the room discussing whose mandate it is.

It's very interesting to watch it unfold, because we're still not sure, nor are they. The task force is in a preliminary stage of "What next?" It's exciting that we had 36 individuals on the phone last time. Chief Meneen is really good at encouraging us: "What was the outcome?" "It was a good call." "What was the outcome?"

We're still not there yet. In your meeting 109, we heard Mr. Conn speak about the 100 recipients of pilot projects. We'd like to be one of those, please. We'll add that as a recommendation.

● (1725)

Mrs. Cathy McLeod: In terms of the other programs that are related to supporting seniors or elders in care, right now the streams are very different, so you probably have the Alberta Health Services providing some for the off reserve and—

The Chair: It will have to be a yes or no answer, because we've run out of time.

Mrs. Cathy McLeod: —the indigenous services providing for on reserve. Is that where we are right now, or is there some blend?

Ms. Natalie Gibson: There's very little blend.

The Chair: Thank you.

We now wrap up with MP Mike Bossio.

Mr. Mike Bossio: A lot of questions have already been asked, and there are a few loose ends I'm trying to get my head around. Robert Ouellette asked a number of questions about training, and I'd like to get a sense from a base level.

Right now it sounds like there are no support workers in health who are local to the communities themselves. Am I right in saying they all come in from the outside? I'm talking in terms of the delivery of home care.

Chief Rupert Meneen: A while back we had issues with dialysis units in the north. Each health centre has health care workers already. We have two nurses in Tallcree. Each community has a couple of nurses. I have volunteered our nurses to be in that facility at some point in time, so they can help with the training or whatever needs to be done in there.

What's really holding it back right now from going into full training mode is the fact that we haven't really gotten to the point where the government has told us it's going to support us and build us a facility. Then I could go out to the ministers or whoever I need to talk to, to say I have to start training people right now. We're not at that point yet where I can go out and start putting these pieces together that need to be put together.

Mr. Mike Bossio: As far as the delivery of home care services within each of the communities is concerned, is that happening today?

Chief Rupert Meneen: Yes.

Mr. Mike Bossio: There are personal support workers and health care professionals who go out to the homes to provide that level of care, but there is not the long-term care.

Chief Rupert Meneen: Yes. We have an organization called the North Peace Tribal Council, of which I'm one of the chiefs, and we have an umbrella group that provides support to the communities right now.

Mr. Mike Bossio: Are they all indigenous individuals who are providing those services today?

Chief Rupert Meneen: Yes, most of them are.

Mr. Mike Bossio: Thank you very much.

The Chair: Thank you very much for coming and providing your information, both on the video conference and here in person. We really appreciate it. We'll be looking at preparing the report over the summer. It will be coming out in the fall. We really want to thank you for your participation.

Meegwetch.

We're done for today.

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